

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008572

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1258

STATE FILE NUMBER

FILED FEB 19 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 14 yr 11 mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Mo.		d. STREET ADDRESS (If outside, give location) 4348 Wallace	
3. NAME OF DECEASED (Type or print) First Middle Last Cora Belle Engelke		4. DATE OF DEATH Month Day Year February 4, 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/27/1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Allenton, Mo.
13a. FATHER'S NAME Robert Charles Allen		13b. MOTHER'S MAIDEN NAME Emily J. Wengler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO. Masonic Home of Mo. 5351 Delmar Blvd.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		Interval between onset and death unknown 181.0	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3/28/48 to 2/4/63 and last saw her alive on 2/4/63 Death occurred at 5:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harold E. Walters M.D.		22b. ADDRESS 3720 Washington St. Allenton, Missouri	
22c. DATE SIGNED 2-5-63		23. NAME OF CEMETERY OR CREMATORY Allenton Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial (Auto)		23b. DATE 2/6/63	
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd		25. DATE RECD. BY LOCAL REG. FEB 6 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBONVS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

ITEM NO.

1  
2 2/59  
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4 1  
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86

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Vernon S. Vetter*

Licensed Embalmer No.

*5031*

P. O. Address

*16175 Delmar  
Shirley No.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Embalmer's Name

Embalmer's Address

Embalmer's License No.

Embalmer's Signature